		FOR OHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046227

Facility Name: Colonial Nursing & Rehabilitation Center

Address: 515 Bureau Valley Parkway (Number) Princeton (City) 61356 (Zip Code)

County: Bureau

Telephone Number: (815) 875-3347 **Fax #** (815) 875-2012

IDPA ID Number: 200837520001

Date of Initial License for Current Owners: 04/01/2005

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL		
	Charitable Corp.		Individual		State		
	Trust		Partnership		County		
IRS Exemption Code			Corporation		Other		
			"Sub-S" Corp.				
		X	Limited Liability Co.				
			Trust				
			Other				

In the event there are further questions about this report, please contact:
Name: David Langsner **Telephone Number:** (847) 905-3206
Please send copies of desk review and audit adjustments to address on this page.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 04/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) David Langsner
(Title) Chief Financial Officer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax #

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Colonial Nursing & Rehabilitation Center # 0046227 Report Period Beginning: 04/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	88	Skilled (SNF)	88	24,200	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	88	TOTALS	88	24,200	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,383	7,103	2,641	21,127	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,383	7,103	2,641	21,127	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.30%

D. How many bed-hold days during this year were paid by the Department? 1 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES [ ] NO [X]

I. On what date did you start providing long term care at this location?

Date started 04/01/2005

J. Was the facility purchased or leased after January 1, 1978?

YES [X] Date 04/01/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?

YES [X] NO [ ] If YES, enter number of beds certified 88 and days of care provided 2,588

Medicare Intermediary AdminaStar Federal Springfield

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Colonial Nursing & Rehabilitation Center # 0046227 Report Period Beginning: 04/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	125,970	11,536	4,875	142,381		142,381		142,381			1
2	Food Purchase		89,027		89,027		89,027	(1,349)	87,678			2
3	Housekeeping	44,199	9,639	3,705	57,543		57,543		57,543			3
4	Laundry	36,477	12,485		48,962		48,962		48,962			4
5	Heat and Other Utilities			63,622	63,622		63,622		63,622			5
6	Maintenance	62,060		20,432	82,492		82,492		82,492			6
7	Other (specify):*											7
8	**TOTAL General Services**	268,706	122,687	92,634	484,027		484,027	(1,349)	482,678			8
	B. Health Care and Programs											
9	Medical Director			4,500	4,500		4,500		4,500			9
10	Nursing and Medical Records	1,138,409	49,634	3,436	1,191,479		1,191,479		1,191,479			10
10a	Therapy		1,321	141,240	142,561		142,561		142,561			10a
11	Activities	38,276	5,802	588	44,666		44,666		44,666			11
12	Social Services	21,695	439	1,665	23,799		23,799		23,799			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,198,380	57,196	151,429	1,407,005		1,407,005		1,407,005			16
	C. General Administration											
17	Administrative	56,528			56,528		56,528	55,000	111,528			17
18	Directors Fees											18
19	Professional Services			52,838	52,838		52,838	(2,382)	50,456			19
20	Dues, Fees, Subscriptions & Promotions			4,986	4,986		4,986		4,986			20
21	Clerical & General Office Expenses	88,017	12,873	16,265	117,155		117,155	(151)	117,004			21
22	Employee Benefits & Payroll Taxes			269,692	269,692		269,692		269,692			22
23	Inservice Training & Education			239	239		239		239			23
24	Travel and Seminar			63	63		63		63			24
25	Other Admin. Staff Transportation			3,960	3,960		3,960		3,960			25
26	Insurance-Prop.Liab.Malpractice			61,487	61,487		61,487		61,487			26
27	Other (specify):*											27
28	**TOTAL General Administration**	144,545	12,873	409,530	566,948		566,948	52,467	619,415			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,611,631	192,756	653,593	2,457,980		2,457,980	51,118	2,509,098			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Colonial Nursing & Rehabilitation Center #0046227 Report Period Beginning: 04/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			1,659	1,659		1,659		1,659			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,395	11,395		11,395	(81)	11,314			32
33	Real Estate Taxes			26,475	26,475		26,475		26,475			33
34	Rent-Facility & Grounds			198,513	198,513		198,513		198,513			34
35	Rent-Equipment & Vehicles			4,068	4,068		4,068		4,068			35
36	Other (specify):*											36
37	**TOTAL Ownership**			242,110	242,110		242,110	(81)	242,029			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		83,613	2,070	85,683		85,683		85,683			39
40	Barber and Beauty Shops			13,982	13,982		13,982		13,982			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,300	36,300		36,300		36,300			42
43	Other (specify):* **Nonallowable Costs**			60,846	60,846		60,846	(60,846)				43
44	**TOTAL Special Cost Centers**		83,613	113,198	196,811		196,811	(60,846)	135,965			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,611,631	276,369	1,008,901	2,896,901		2,896,901	(9,809)	2,887,092			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See Schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Colonial Nursing & Rehabilitation Center # 0046227 Report Period Beginning: 04/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(81)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(672)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(594)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(23,400)	43		24
25	Fund Raising, Advertising and Promotional	(28,789)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Sch5A	43,727			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (9,809)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (9,809)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Colonial Nursing & Rehabilitation Center
Provider #: 0046227
04/01/05 to 12/31/05 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference
To disallow Out of Period Legal Fee	(2,382)	19
To offset Vending Income	(1,349)	2
To offset Other Income	(100)	21
To offset Jury Duty Income	(51)	21
To disallow Collection Exp	(156)	43
To disallow Laboratory Exp	(3,903)	43
To disallow Radiology Exp	(3,332)	43
Owner Compensation	55,000	17
Total	43,727	

STATE OF ILLINOIS **Page 5A**

Colonial Nursing & Rehabilitation Center

ID# **0046227**

Report Period Beginning: **04/01/05**

Ending: **12/31/05**

	NON-ALLOWABLE EXPENSES	**Amount**	**Sch. V Line Reference**	
1	Misc. - Part A	**$**		**1**
2	Labs - Part A			**2**
3	X-Rays - Part A			**3**
4	Vending Machine Expense			**4**
5	Disallowed Non-Care Related Real Estate Tax			**5**
6				**6**
7				**7**
8				**8**
9				**9**
10				**10**
11				**11**
12				**12**
13				**13**
14				**14**
15				**15**
16				**16**
17				**17**
18				**18**
19				**19**
20				**20**
21				**21**
22				**22**
23				**23**
24				**24**
25				**25**
26				**26**
27				**27**
28				**28**
29				**29**
30				**30**
31				**31**
32				**32**
33				**33**
34				**34**
35				**35**
36				**36**
37				**37**
38				**38**
39				**39**
40				**40**
41				**41**
42				**42**
43				**43**
44				**44**
45				**45**
46				**46**
47				**47**
48				**48**
49	**Total**	0		**49**

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Colonial Nursing & Rehabilitation Center **#** 0046227 **Report Period Beginning:** 04/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Colonial Nursing & Rehabilitation Center** **#** **0046227** **Report Period Beginning:** **04/01/05** **Ending:** **12/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(81)	0	0	0	0	0	0	0	0	0	0	(81)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(81)	0	0	0	0	0	0	0	0	0	0	(81)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(53,455)	0	0	0	0	0	0	0	0	0	0	(53,455)	43
44	**TOTAL Special Cost Centers**	(53,455)	0	0	0	0	0	0	0	0	0	0	(53,455)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(53,536)	0	0	0	0	0	0	0	0	0	0	(53,536)	45

Facility Name & ID Number Colonial Nursing & Rehabilitation Center # 0046227 Report Period Beginning: 04/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Nathan Lansgner	99%	River Shore Rehabilitation and Nursing Center	Marseilles, IL	N/A		
David Langsner	1%	Clark Nursing and Rehab Center	Gary, IN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Colonial Nursing & Rehabilitation Center # 0046227 Report Period Beginning: 04/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Nathan Langsner	Owner	Administrative	99.0000%	20,000	5	10%	Owner Comp	$ 30,000	17-3	1
2	David Langsner	Owner	Administrative	1.0000%	15,000	5	10%	Owner Comp	25,000	17-3	2
3	Ruth Langsner	Relative	Bookkeeper		40,122	20	50%	Salary	40,122	21-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 95,122		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number **Colonial Nursing & Rehabilitation Center** **SCH7A**

**0046227**

Report Period Beginning: **04/01/05** **Ending:** **12/31/05**

Individual Name	Facility Name	Hours	Amount
Nathan Langsner	River Shore Rehabilitstion & Nursing Center	5	20,000
David Langsner	River Shore Rehabilitstion & Nursing Center	5	15,000
Ruth Langsner	River Shore Rehabilitstion & Nursing Center	20	40,122

Facility Name & ID Number Colonial Nursing & Rehabilitation Center # 0046227 Report Period Beginning: 04/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3		n/a								3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Colonial Nursing & Rehabilitation Center # 0046227 Report Period Beginning: 04/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LaSalle Bank		x	Line of Credit				259,740			11,395	6
7												7
8												8
9	TOTAL Facility Related						$	$ 259,740			$ 11,395	9
	B. Non-Facility Related*											
10	Interest Income										(81)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (81)	14
15	TOTALS (line 9+line14)						$	$ 259,740			$ 11,314	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Colonial Nursing & Rehabilitation Center # 0046227 **Report Period Beginning:** 04/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	**2004**	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 26,475	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 26,475	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	29,774	8
	2001	32,412	9
	2002	32,104	10
	2003	33,394	11
	2004	33,651	12

Real Estate Acrrual = 2004 R/E 33,651 x 1.05 = 35,300/(9/12) =26,475

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Colonial Nursing & Rehabilitation Cente COUNTY Bureau

FACILITY IDPH LICENSE NUMBER 0046227

CONTACT PERSON REGARDING THIS REPORT David Langsner

TELEPHONE (847) 905-3206 FAX #: (847) 905-3030

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-15-301-008	Long Term Care Property	$ 437.46	$ 437.46
2.	16-15-301-009	Long Term Care Property	$ 437.46	$ 437.46
3.	16-15-303-020	Long Term Care Property	$ 32,775.96	$ 32,775.96
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 33,650.88	$ 33,650.88

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2005

Facility Name & ID Number Colonial Nursing & Rehabilitation Center # 0046227 Report Period Beginning: 04/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,295 B. General Construction Type: Exterior Brick Frame Steel Stud Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	N/A			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Colonial Nursing & Rehabilitation Center # 0046227 Report Period Beginning: 04/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking Lot			2005	10,776	673	8	673		673	9
10	Water Heater			2005	4,495	225	10	225		225	10
11	Water Heater			2005	4,174	209	10	209		209	11
12	Windows			2005	25,536	327	39	327		327	12
13	Carpet			2005	2,767	138	10	138		138	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Colonial Nursing & Rehabilitation Center # 0046227 Report Period Beginning: 04/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 47,748	$ 1,572		$ 1,572	$	$ 1,572	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Colonial Nursing & Rehabilitation Center # 0046227 Report Period Beginning: 04/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases	874	87	87		5 yrs.	87	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 874	$ 87	$ 87	$		$ 87	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 48,622	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,659	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,659	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,659	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Colonial Nursing & Rehabilitation Center # 0046227 Report Period Beginning: 04/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Colonial Priceton Property LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		88	04/01/2005	$ 197,538	6		3
4	Additions							4
5								5
6	Storage Unit Rental				975			6
7	TOTAL		88		$ 198,513 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A . N/A

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning 04/01/05
Ending 03/31/11

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2006	$ 277,836
13.	12/31/2007	$ 284,259
14.	12/31/2008	$ 290,688

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 4,068 Description: $957 Postage Meter, $2646 Copier, $465 Oxegyn Concentrator
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	N/A				18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Colonial Nursing & Rehabilitation Center # 0046227 Report Period Beginning: 04/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Colonial Nursing & Rehabilitation Center # 0046227 Report Period Beginning: 04/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10a,C2	hrs	$		$ 21,153	$		$ 21,153	1
2	Licensed Speech and Language Development Therapist	L10a,C3	hrs			1,110			1,110	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a,C3	hrs			118,977			118,977	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39,C2	# of prescrpts				55,089		55,089	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Sch16A					2,070	29,845		31,915	13
14	TOTAL			$		$ 143,310	$ 84,934		$ 228,244	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Colonial Nursing & Rehabilitation Center
Provider #: 0046227
04/01/05 to 12/31/05 **Schedule 16A**

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
Therapy And Rehab. Supplies	L 10A C 2			1,321
Ventilation Equipment	L 10A C 3		2,070	
Air Fluidized Beds	L 39 C 2			5,830
Oxygen	L 39 C 2			2,228
Other Services Medicare	L 39 C 2			2,912
Food Pump	L 39 C 2			723
Medical Supplies Chargeable				16,831
Total			2,070	29,845

STATE OF ILLINOIS

Facility Name & ID Number Colonial Nursing & Rehabilitation Center # 0046227 **Report Period Beginning:** 04/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 162,644	$ 162,644	1
2	Cash-Patient Deposits	4,577	4,577	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 34,888)	545,196	545,196	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,283	13,283	6
7	Other Prepaid Expenses	11,657	11,657	7
8	Accounts Receivable (owners or related parties)	3,680	3,680	8
9	Other(specify):	20,124	20,124	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 761,161	$ 761,161	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	47,748	47,748	15
16	Equipment, at Historical Cost	874	874	16
17	Accumulated Depreciation (book methods)	(1,659)	(1,659)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Utility Deposit	263	263	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 47,226	$ 47,226	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 808,387	$ 808,387	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 47,822	$ 47,822	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	478	478	28
29	Short-Term Notes Payable	259,740	259,740	29
30	Accrued Salaries Payable	136,567	136,567	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,400	10,400	31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,475	26,475	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	157,134	157,134	36
37	See Sch 17A	310,387	310,387	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 949,003	$ 949,003	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 949,003	$ 949,003	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (140,616)	$ (140,616)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 808,387	$ 808,387	48

***(See instructions.)**

Colonial Nursing & Rehabilitation Center
0046227
12/31/05

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.

A. Current Assets

Other Current Assets (specify):	Operating	After Consolidation
Total Line 9 - Other Current Assets(specify):	**0**	**0**

B. Long Term Assets

Other Long Term Assets (specify):	Operating	After Consolidation
Total Line 23 - Other Long Term Assets Assets(spec	**0**	**0**

C. Current Liabilities

Other Current Liabilities (specify):	Operating	After Consolidation
Due From Employees	357	357
Accrued Expenses	113,444	113,444
A/R - Due To Medicaid	35,516	35,516
Payroll Deduction - Life Insurance	1,087	1,087
Payroll Deduction - 401K	6,730	6,730
Total Line 36 - Other Current Liabilities(specify):	**157,134**	**157,134**

Other Current Liabilities (specify):

Other Current Liabilities (specify):	Operating	After Consolidation
Due To Others	1,000	1,000
Due To Others Related Parties	15,511	15,511
Due To Prior Owners	293,876	293,876
Total Line 37 - Other Current Liabilities(specify):	**310,387**	**310,387**

Facility Name & ID Number Colonial Nursing & Rehabilitation Center **#** 0046227 **Report Period Beginning:** 04/01/05 **Ending:** 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(140,616)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (140,616)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (140,616)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

Facility Name & ID Number Colonial Nursing & Rehabilitation Center # 0046227 Report Period Beginning: 04/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,618,364	1
2	Discounts and Allowances for all Levels	(546,156)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,072,208	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	506,879	6
7	Oxygen	180	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 507,059	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	14,101	13
14	Non-Patient Meals	4,459	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	50,857	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,410	19
20	Radiology and X-Ray	3,473	20
21	Other Medical Services	91,262	21
22	Laundry	4,875	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 175,437	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	81	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 81	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Sch 19A	1,500	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,500	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,756,285	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	484,027	31
32	Health Care	1,407,005	32
33	General Administration	566,948	33
	B. Capital Expense		
34	Ownership	242,110	34
	C. Ancillary Expense		
35	Special Cost Centers	160,511	35
36	Provider Participation Fee	36,300	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,896,901	40
41	**Income before Income Taxes (line 30 minus line 40)****	(140,616)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (140,616)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Colonial Nursing & Rehabilitation Center
0046227
12/31/05

Schedule 19A

XVII. INCOME STATEMENT
Revenue

E. Other Revenue (specify):	Amount
Vending Income	(1,349)
Other Income	(100)
Jury Duty	(51)
Total Line 28 - Other Revenue (specify):	**(1,500)**

Facility Name & ID Number Colonial Nursing & Rehabilitation Center # 0046227 Report Period Beginning: 04/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,297	1,569	$ 51,112	$ 32.58	1
2	Assistant Director of Nursing	764	1,497	43,543	29.09	2
3	Registered Nurses	11,256	12,728	294,569	23.14	3
4	Licensed Practical Nurses	6,296	7,073	133,523	18.88	4
5	CNAs & Orderlies	36,982	40,009	455,809	11.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,326	1,481	20,404	13.78	9
10	Activity Assistants	2,139	2,308	17,872	7.74	10
11	Social Service Workers	1,411	1,517	21,695	14.30	11
12	Dietician					12
13	Food Service Supervisor	1,367	1,587	32,335	20.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,090	4,580	46,106	10.07	15
16	Dishwashers	6,118	6,640	47,529	7.16	16
17	Maintenance Workers	2,627	3,206	48,919	15.26	17
18	Housekeepers	5,438	5,778	44,199	7.65	18
19	Laundry	3,985	4,272	36,477	8.54	19
20	Administrator	1,358	1,514	56,528	37.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,401	4,817	88,017	18.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,170	1,337	19,753	14.77	31
32	Other Health Ca See Sch20A	7,464	8,855	140,100	15.82	32
33	Other(specify) See Sch20A	1,304	1,231	13,141	10.68	33
34	TOTAL (lines 1 - 33)	100,793	111,999	$ 1,611,631 *	$ 14.39	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	110	$ 4,875	L.1 C. 3	35
36	Medical Director	Monthly	4,500	L.9 C. 3	36
37	Medical Records Consultant	Monthly	171	L.10 C. 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,157	L.10 C. 3	39
40	Physical Therapy Consultant			L.10a C. 3	40
41	Occupational Therapy Consultant			L.10a C. 3	41
42	Respiratory Therapy Consultant			L.10a C. 3	42
43	Speech Therapy Consultant			L.10a C. 3	43
44	Activity Consultant	12	588	L.11 C. 3	44
45	Social Service Consultant	25	1,665	L.12 C. 3	45
46	Other(specify) MDS Consultant	12	394	L.10 C. 3	46
47	Dental Consultant	monthly	714	L.10 C. 3	47
48					48
49	TOTAL (lines 35 - 48)	159	$ 15,064		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	n/a	$	L. 10 C. 3	50
51	Licensed Practical Nurses	n/a		L. 10 C. 3	51
52	Certified Nurse Assistants/Aides	n/a		L. 10 C. 3	52
53	TOTAL (lines 50 - 52)		$		53

Colonial Nursing & Rehabilitation Center
0046227
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Schedule 20A

XVIII. STAFFING AND SALARY COSTS
LINE 32 - Other (Health Care specify)

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Supply Clerk	1,432	1,669	$ 19,962	11.96
Ward Clerk	1,402	1,650	$ 19,909	12.07
Rehab Aides	2,592	2,990	$ 37,409	12.51
Care Plan Coordinator	2,038	2,546	$ 62,820	24.67
Total Line 32 - Other	**7,464**	**8,855**	**$ 140,100**	**$ 15.82**

XVIII. STAFFING AND SALARY COSTS
LINE 33 - Other (specify)

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Maint/Hskg Director	1,304	1,231	$ 13,141	10.68
Total Line 33 - Other	**1,304**	**1,231**	**$ 13,141**	**$ 10.68**

Colonial Nursing & Rehabilitation Center
0046227
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Schedule 20B

XVIII. Consultant Services
LINE 46

	# of Hrs. Actually Worked	Reporting Period Total Consultant Costs	Schedule V Line & Column
Total Line 46 - Other	**0**	**$ -**	

Facility Name & ID Number Colonial Nursing & Rehabilitation Center # 0046227 Report Period Beginning: 04/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Robert D Yearian	Administrator	0	$ 56,528
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 56,528

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
Lawrence Schwartz	Legal	2,762
Katz & Miller	Accounting	9,450
Talx Corp	Unemployment Consult	255
Prospect Resource	Natural Gas Procurement	300
Michelle Frauendorff	Therapy Program Consult	96
ADP, Inc	Payroll Services	3,086
ITT/Sourcetech	Computer Support	260
Optimizer System	Medicare Software	125
Achieve Health Care	Software Support	7,630
Ehealth Data Solutions	Billing Program System	1,770
See Schedule 21A		27,104
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 52,838

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,059
Unemployment Compensation Insurance	24,723
FICA Taxes	121,851
Employee Health Insurance	58,956
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	2,071
Other Misc. Employee Benefits	4,032
TOTAL (agree to Schedule V, line 22, col.8)	$ 269,692

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,105
Health Care Worker Background Check	
(Indicate # of checks performed 24)	528
Various Dues	1,218
Various Subscriptions	353
Various Fees	782
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,986

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	63
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 63

**See instructions.

Colonial Nursing & Rehabilitation Center
Provider #: 0046227
04/01/05 to 12/31/05 **Schedule 21A**

XIX. SUPPORT SCHEDULE

C. Professional Services

Care Centers, Inc	Accounting Services	15,840
Care Centers, Inc	Account Receivables	11,264
Total (agree to Schedule V, line 19, column 3)		52,838
To disallow legal fees out of Period		(2,382)
Total (agree to Schedule V, line 19, column 8)		50,456

Facility Name & ID Number Colonial Nursing & Rehabilitation Center # 0046227 Report Period Beginning: 04/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Colonial Nursing & Rehabilitation Center # 0046227 Report Period Beginning: 04/01/05 Ending: 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,501** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **36,300**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	125,970	11,536	4,875	142,381	0	142,381	0	142,381
2. Food Purchase	0	89,027	0	89,027	0	89,027	(1,349)	87,678
3. Housekeeping	44,199	9,639	3,705	57,543	0	57,543	0	57,543
4. Laundry	36,477	12,485	0	48,962	0	48,962	0	48,962
5. Heat and Other Utilities	0	0	63,622	63,622	0	63,622	0	63,622
6. Maintenance	62,060	0	20,432	82,492	0	82,492	0	82,492
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	268,706	122,687	92,634	484,027	0	484,027	(1,349)	482,678
9. Medical Director	0	0	4,500	4,500	0	4,500	0	4,500
10. Nursing & Medical Records	1,138,409	49,634	3,436	1,191,479	0	1,191,479	0	1,191,479
10a. Therapy	0	1,321	141,240	142,561	0	142,561	0	142,561
11. Activities	38,276	5,802	588	44,666	0	44,666	0	44,666
12. Social Services	21,695	439	1,665	23,799	0	23,799	0	23,799
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,198,380	57,196	151,429	1,407,005	0	1,407,005	0	1,407,005
17. Administrative	56,528	0	0	56,528	0	56,528	55,000	111,528
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	52,838	52,838	0	52,838	(2,382)	50,456
20. Fees, Subscriptions & Promotion	0	0	4,986	4,986	0	4,986	0	4,986
21. Clerical & General Office	88,017	12,873	16,265	117,155	0	117,155	(151)	117,004
22. Employee Benefits & Payroll	0	0	269,692	269,692	0	269,692	0	269,692
23. Inservice Training & Education	0	0	239	239	0	239	0	239
24. Travel and Seminar	0	0	63	63	0	63	0	63
25. Other Admin. Staff Trans	0	0	3,960	3,960	0	3,960	0	3,960
26. Insurance-Prop.Liab.Malpractice	0	0	61,487	61,487	0	61,487	0	61,487
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	144,545	12,873	409,530	566,948	0	566,948	52,467	619,415
29. Total General Administrative	1,611,631	192,756	653,593	2,457,980	0	2,457,980	51,118	2,509,098
30. Depreciation	0	0	1,659	1,659	0	1,659	0	1,659
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	11,395	11,395	0	11,395	(81)	11,314
33. Real Estate	0	0	26,475	26,475	0	26,475	0	26,475
34. Rent - Facility & Grounds	0	0	198,513	198,513	0	198,513	0	198,513
35. Rent - Equipment & Vehicles	0	0	4,068	4,068	0	4,068	0	4,068
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	242,110	242,110	0	242,110	(81)	242,029
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	83,613	2,070	85,683	0	85,683	0	85,683
40. Barber and Beauty Shop	0	0	13,982	13,982	0	13,982	0	13,982
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	36,300	36,300	0	36,300	0	36,300
43. Other (specify):*	0	0	60,846	60,846	0	60,846	(60,846)	0
44. Total Special Cost Ce	0	83,613	113,198	196,811	0	196,811	(60,846)	135,965
45. Grand Total	1,611,631	276,369	1,008,901	2,896,901	0	2,896,901	(9,809)	2,887,092

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	162,644	162,644
2. Cash - Patient Deposits	4,577	4,577
3. Accounts & Notes Recievable	545,196	545,196
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	13,283	13,283
7. Other Prepaid Expenses	11,657	11,657
8. Accounts Receivable-Owner/Related Party	3,680	3,680
9. Other (specify):	20,124	20,124
10. Total current assets	761,161	761,161
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	0
14. Buildings, at Historical Cost	0	0
15. Leasehold Improvements, Historical Cost	47,748	47,748
16. Equipment, at Historical Cost	874	874
17. Accumulated Depreciation (book methods)	-1,659	-1,659
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	263	263
24. Total Long-Term Assets	47,226	47,226
25. Total Assets	808,387	808,387
CURRENT LIABILITIES		
26. Accounts Payable	47,822	47,822
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	478	478
29. Short-Term Notes Payable	259,740	259,740
30. Accrued Salaries Payable	136,567	136,567
31. Accrued Taxes Payable	10,400	10,400
32. Accrued Real Estate Taxes	26,475	26,475
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	157,134	157,134
37. Other Current Liabilities (specify):	310,387	310,387
38. Total Current Liabilities	949,003	949,003
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	0
46.Total Liabilities	949,003	949,003
47.Total Equity	-140,616	-140,616
48.Total Liabilities and Equity	808,387	808,387

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,618,364
2. Discounts and Allowances for all Levels	-546,156
Subtotal - Inpatient Care	2,072,208
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	506,879
7. Oxygen	180
Subtotal - Anciliary Revenue	507,059
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	14,101
14. Non-Patient Meals	4,459
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	50,857
18. Sale of Supplies to Non-Patients	0
19. Laboratory	6,410
20. Radiologyand X-Ray	3,473
21. Other Medical Services	91,262
22. Laundry	4,875
Subtotal - Other Operating Revenue	175,437
24. Contributions	0
25. Interest and Other Investments Income	81
Subtotal - Non-Operating Revenue	81
27. Other Revenue (specify):	1,500
28. Other Revenue (specify):	0
Subtotal - Other Revenue	1,500
30. Total Revenue	2,756,285
31. General Services	0
32. Health Care	0
33. General Administration	0
34. Ownership	0
35. Special Cost Centers	0
35. Provider Participation Fee	0
37. Other	0
40. Total Expenses	0
41. Income Before Income Taxes	2,756,285
42. Income Taxes	0
43. Net Income or Loss for the Year	2,756,285

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